

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G268 8-8-60 et

Reg. Dist. No.

07496

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Memorial Hospital</u>				d. STREET ADDRESS <u>Route 4,</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JANIE</u>		First <u>BAKER</u>		Middle <u>BAKER</u>		Last <u>BAKER</u>	
4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 60</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Oct. 30, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u>		IF UNDER 24 HRS. Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Piper</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Mansfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Albert H. Baker</u> Address <u>Route 4, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20a. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>July 30, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. E. Kight</u>	

WISCONSIN STATE DEPARTMENT OF HEALTH—MILWAUKEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7511

07497

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 78 1/2 DOUGLAS AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNA Middle M. Last BARCLAY		4. DATE OF DEATH Month JULY Day 1 Year 1960					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD GARLITZ				14. MOTHER'S MAIDEN NAME SUSIE PLUCKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anger Bowel DUE TO Emboli, mesenteric artery and pulmonary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension and arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Men. arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days 10 days? 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 25 July 1960 to 1 Aug 1960 that (I) was last saw the deceased alive on 1 Aug 1960 and that death occurred at 4:38 PM from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ALFRED VAN ORMER				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF 7/4/1960		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR DATE JUL 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

02452

CERTIFICATE OF DEATH

11511



WILLIAM

MURRAY

ALLISON

LOWELL

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181 BOSTON AVE.

181 BOSTON AVE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7512

07498

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 28 DAYS			
d. NAME OF HOSPITAL (If in hospital, give hospital name) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BELVA Middle MAY Last BARNES				4. DATE OF DEATH Month JULY Day 15 Year 19 60.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 3, 1905	
9. AGE (In years last birthday) 54 yrs.		10. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home			
13. FATHER'S NAME JOHNSON COLLINS				14. MOTHER'S MAIDEN NAME ELIZABETH JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident & right heart failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Hypertensive arteriosclerotic CVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 28 days INTERVAL BETWEEN ONSET AND DEATH 28 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/17 1960 to 7/15 1960 that (I) (we) last saw the deceased alive on 7/15 1960 and that death occurred at 2:40 PM from the causes and on the date stated above.							
22a. SIGNATURE George M. Simon 22c. PHYSICIAN'S NAME (Type) GEORGE M. SIMON DR. XXXXXXXXXX				22b. DATE SIGNED 7/17/60 22d. ADDRESS ALGONQUIN HOTEL, XXXXXX CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/60		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town, or county) (State) Near Clearville Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox ADDRESS Cumberland Maryland				25a. REC'D BY REGISTRAR DATE JUL 20 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

07198

7519

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
STATE OF NEW YORK

WEDNESDAY

WEDNESDAY

WEDNESDAY

CU PEARL

88 DAYS

CHIEF

RT. 41, VALLEY ROAD

MEMORIAL HOSPITAL
NEW YORK

JULY

BARRIS

MAY

DELA

31

DECEMBER 1, 1925

CLARK WHITE

1200 1/2 AVENUE

1200 1/2 AVENUE

1200 1/2 AVENUE

ELIZABETH HENRY

JOHN COLEMAN

MEMORIAL HOSPITAL - CLEVELAND, OH.

1200 1/2 AVENUE

1200 1/2 AVENUE

WEDNESDAY

WEDNESDAY

WEDNESDAY

DEPARTMENT OF HEALTH

STATE OF NEW YORK

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7565

07499

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b 9 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORA Middle ELLEN Last BENNETT				4. DATE OF DEATH Month JULY Day 7, Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 3, 1893	
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ORNDORFF				14. MOTHER'S MAIDEN NAME ELIZA QUICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 214-32-3449A			
17. INFORMANT FRANK BENNETT, MT. SAVAGE, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hr. 15 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) did not attended the deceased from March 1, 1960 to July 7, 1960 that (I) was last saw the deceased alive on July 7, 1960 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Alvin J. Walters				22b. DATE July 8, 1960			
22c. PHYSICIAN'S NAME (Type) Alvin J. Walters, M. D.				22d. ADDRESS 48 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-10-1960		23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY		23d. LOCATION (City, town, or county) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Hurst				25a. REC'D BY REGISTRAR DATE JUL 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	
ADDRESS FROSTBURG, MD.							

(M)

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02450

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(1)

THE FOLLOWING INFORMATION WAS OBTAINED FROM THE
RECORDS OF THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES, DIVISION OF VITAL RECORDS
ON JULY 2, 1960.
NAME: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
SEX: [illegible]
RACE: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
RESIDENCE: [illegible]
MILITARY SERVICE: [illegible]
REMARKS: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Lawrence</u> Last <u>Bohn</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>19 60</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Hill High School</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Solomon Bohn</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Huffman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-03-0854</u>		17. INFORMANT Address <u>Mrs. Clara Bohn Ellerslie, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (c) <u>gave rise to immediate cause (a), stating the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420</u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>JULY 8, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Buffalo Mills RD#1, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey A. Feigler</u>				ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>			
						24b. REGISTRAR'S SIGNATURE <u>Catharine S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

7566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07501

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES First W. Middle BOWDEN Last		4. DATE OF DEATH 7/1/1960 Month 7 Day 1 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/1903
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 7	IF UNDER 24 HRS. Hours 1 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Bowden		14. MOTHER'S MAIDEN NAME Annie Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Charles Bowden Address , Frostburg, MD.		(WIFE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 540.0 (b) Peritonitis DUE TO 11000 (c) Ruptured gastric ulcer DUE TO 8 day PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Primary Carcinoma Left Lung Left Nephrolithiasis		INTERVAL BETWEEN ONSET AND DEATH 2-3 day 11000 8 day	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/23 19 60 to 7/1 19 60 that (I) (we) lost saw the deceased alive on 7/1 19 60 and that death occurred on 11/24/61 from the causes and on the date stated above.			
22a. SIGNATURE John B. Davis M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/1/60	
22c. PHYSICIAN'S NAME (Type) John B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/4/1960	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR DATE JUL 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10501

CERTIFICATE OF DEATH

10501

Allegany

Allegany

Allegany

PROCTOR

PROCTOR

Allegany Hospital

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany, West Virginia

Allegany

Allegany

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Allegany, West Virginia

Allegany

Allegany

Allegany

Allegany

Allegany, West Virginia

Allegany

7513

CERTIFICATE OF DEATH

07502

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2031 Bedford Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Cooper Last Bracey				4. DATE OF DEATH Month July Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (retired) Education			10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME William Cooper				14. MOTHER'S MAIDEN NAME Irene Denson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-38-5551		17. INFORMANT Address Earle L. Bracey 2031 Bedford Rd. Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cancer of the pituitary gland 195.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-3- , 19 58 , to 7-24- , 19 60 , that I last saw the deceased alive on 7-14- , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE L. Bracey M.D. 57 Queen St. PHYSICIAN'S NAME (Type) Cumberland Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 July 1960		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis S. Smith				24a. REC'D. BY REGISTRAR JUL 28 60		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	
17 Frederick St. Cumb. Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

7514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07503

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 15 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. STREET ADDRESS 1 Mt Savage		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB		First JACOB Middle P Last BRIDGES		4. DATE OF DEATH Month JULY Day 13 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 9, 1875	
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner Mining				10b. KIND OF BUSINESS OR INDUSTRY Retired Coal Miner Mining		11. BIRTHPLACE (State or foreign country) PENNA.	
13. FATHER'S NAME RILEY BRIDGES				14. MOTHER'S MAIDEN NAME OSTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7/12/60 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumbersburg, Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/12/60 19 7/13/60 , that (I) (we) last saw the deceased alive on 7/13/60 , and that death occurred on 7/13/60 at 10:25 AM from the causes and on the date stated above.							
22a. SIGNATURE R. J. Williams		22b. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS		22c. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.		22d. DATE 7/14/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/60		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION (City, town, or county) (State) 1 Mt Savage Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Steen Inc. Camb. Md				25a. REC'D BY REGISTRAR DATE JUL 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kinas	

07013

CERTIFICATE OF DEATH

7514

WILLIAM

WILLIAM

WILLIAM



17. 21. 1901

17. 1901

1001 E. WASHINGTON AVE.
CHICAGO, ILL.

CHICAGO

CHICAGO

JANUARY 9, 1901

CHICAGO

U.S.A.

CHICAGO

CHICAGO

CHICAGO



CHICAGO, ILL.

[Faint, illegible text and signatures, likely bleed-through from the reverse side of the document.]

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE OHIO b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYTON 72X-3	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES ALBERTA BURDRIDGE		4. DATE OF DEATH Month Day Year JULY 10, 19 60	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 10, 1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. JONES		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MADELINE MILLER,		Address 1807 DAYON PLACE, DAYTON 8, OHIO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		DATE SIGNED July 11, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-14-1960	
22c. NAME OF CEMETERY OR CREMATORY GREENCASTLE CEMETERY		22d. LOCATION (City, town, or county) (State) DAYTON, OHIO.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Duret		ADDRESS FROSTBURG, MD.	
24a. REC'D BY REGISTRAR JUL 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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7515

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07505

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle T. Last BURLEY				4. DATE OF DEATH Month JULY Day 7 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 17, 1869	
9. AGE (In years lost birthday) 91 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY B+O R R		11. BIRTHPLACE (State or foreign country) PENNA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME NELSON BURLEY			
14. MOTHER'S MAIDEN NAME CATHERINE KERCHNER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. —				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9 - 16 19 49 to 7 - 7 19 60 that (I) (we) last saw the deceased alive on 7 - 7 19 60 , and that death occurred 9:30 AM on the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin.				22b. DATE SIGNED 7-8-60			
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.				22d. ADDRESS 62 Greene St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/10/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pl.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md		25a. REC'D BY REGISTRAR JUL 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

05200

CHURCH OF DEATH

1915



ALLEGY

IMPLYING

ALLEGY

OF DEATH

IN A CEMETERY

2 DAYS

MEMORIAL HOSPITAL

200 MAY 1915

10

JULY

ELLY

T.

CHARLES

MARCH 1915

UNITED STATES

U.S.A.

SEVEN

PERSON DURELY

CATHERINE MURPHY

MEMORIAL HOSPITAL, CHICAGO, ILL.

10

CHURCH OF DEATH

MEMORIAL HOSPITAL, CHICAGO, ILL.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7579

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07506

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>		c. LENGTH OF STAY IN 1b <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>120 Polk Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William T. Byrne</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1932</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Service, Ocean Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Byrne Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bush.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>220-28 7605</u>	
17. INFORMANT <u>Mrs Martha Byrne Cumberland, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull</u> DUE TO <u>825x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Automobile Accident</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/16</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Midland, Allegany, MD.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skiterelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skiterelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/ 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1937

MASSACHUSETTS

Underland

127 Main Street

William J. Harris

White

Male

Chief

John J. Harris

127-128 Main

Underland

ADD NOTICE

Underland, William J.

Underland, William J.

Underland, William J.

Underland, William J.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07507**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Castle Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle BYRNES Last				4. DATE OF DEATH Month 7 Day 16 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1955	
9. AGE (In years last birthday) 5 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Cumberland, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Byrne				14. MOTHER'S MAIDEN NAME Dorothy Keating			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Paul Byrne, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO (b) Skull fracture Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7/16/1960 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Midland Allegany MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarellic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/16/1960			
EXAMINER'S NAME (Type) Benedict Skitarellic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/19/1960		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE JUL 20 '60	
				24b. REGISTRAR'S SIGNATURE <i>William S. Farnsworth</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7581

CERTIFICATE OF DEATH

07508

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 2 Cumberland,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest Drive		d. STREET ADDRESS Hillcrest Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last CARNEY		4. DATE OF DEATH Month July Day 5, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering	
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Joseph Carney		14. MOTHER'S MAIDEN NAME Mary Ellen Logsdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Leo Mills		Address Rt. # 1 Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 8 , 19 59 , to June 30 , 19 60 , that I last saw the deceased alive on 30 June , 19 60 , and that death occurred at 10:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Michael Glick M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 126 N. Smallwood St. 7/6/60	
PHYSICIAN'S NAME (Type) L. Michael Glick, M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JOHNS HOSPITAL, 1000 W. 10TH AVE., ST. LOUIS, MO. 63104

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kelly Springfield Tire Co.			d. STREET ADDRESS 209 Grand Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT J. CARROLL			4. DATE OF DEATH Month JULY Day 27 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1909		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert W. Carroll			
14. MOTHER'S MAIDEN NAME Lulu M. Pyles		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1928-1934			
16. SOCIAL SECURITY NO. 214-05-5338		17. INFORMANT Constance L. Carroll Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JULY 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
22d. LOCATION (City, town, or county) Cumberland, Maryland		22e. LOCATION (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc.		ADDRESS 117 Frederick St. Cumb. Md.		24a. REC'D BY REGISTRAR AUG 1 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Kenna					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07510

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland. Rural nr, Cresaptown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. NAME OF DECEASED (Type or print) Harman First Middle Last				4. DATE OF DEATH July 26 1960 Month Day Year			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 12, 1887			
9. AGE (In years last birthday) 73 yrs.				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm			
11. BIRTHPLACE (State or foreign country) Custel, Mineral Co., W.Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Aaron Chilcott				14. MOTHER'S MAIDEN NAME Mary Bane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. James P. McCusker, Cresaptown, Maryland			
17. INFORMANT James P. McCusker, Cresaptown, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							
DUE TO (b) Hypertensive Cardio-Vascular Disease							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 5 hours							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Benedict Skitarelic, MD. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 26, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF July 28, 1960							
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park							
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland							
ADDRESS							
24a. REC'D BY REGISTRAR July 29 '60							
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1

7518

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07511

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 87 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 437 Henderson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Margaret Last Creegan		4. DATE OF DEATH Month July Day 17 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Simpson		14. MOTHER'S MAIDEN NAME Johanna Hensey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bernard Creegan		18. 437 Henderson Avenue, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1960 to July 17, 1960 that (I) (we) last saw the deceased alive on July 3, 1960 and that death occurred at 11 from the causes and on the date stated above.			
22a. SIGNATURE D. J. Johnson		22b. DATE 7-18-60	
22c. PHYSICIAN'S NAME (Type) D. J. Johnson		22d. ADDRESS 16 Greene St, Cumberland, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR JUL 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7519
CERTIFICATE OF DEATH
07512

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 59 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS R.F.D.#1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A Last CROSTON		4. DATE OF DEATH Month JULY Day 16 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 19, 1903 56 yrs.
9. AGE (In years lost birthday) 56		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) HOFFMAN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP BRODE		14. MOTHER'S MAIDEN NAME ELIZABETH SLEEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal Lipodystrophy (Whipple's) DUE TO (c) Intestinal Lipodystrophy (Whipple's) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (I) (b) Intestinal Lipodystrophy (Whipple's)		INTERVAL BETWEEN ONSET AND DEATH Symptoms before May '60	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 18, 1960 to 7-16-1960 that (we) last saw the deceased alive on 7-15-1960 and that death occurred at 7:35 AM from the causes and on the date stated above.			
22a. SIGNATURE W.F. Williams M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W.F. WILLIAMS		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-18-60	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J.R. Durst		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

14

7512

CERTIFICATE OF DEATH

05515

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND STATISTICS

ALLIANCE

HARVARD

WILSON

RECORDS

NO. 1000

CHURCH

1910

REPORT A. W. L. A. C. I.

CHURCH

W. L.

OUT OF 10,000

WHITE

WHITE

CHURCH, HARVARD

W. L. A. C. I.

WHITE

CHURCH, HARVARD

WHITE

MENTAL HOSPITAL, HARVARD

192 SOUTH CENTRE ST., CAMBRIDGE, MASS.

W. L. A. C. I.

1910

W. L. A. C. I.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7520

07513

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle ALEDIA Last DEVER				4. DATE OF DEATH Month JULY Day 21 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 18, 1902	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Public				10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) MARYLAND Barton	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES LYONS				14. MOTHER'S MAIDEN NAME MARY SNYDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease I DUE TO Coronary Thrombosis Candidates, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia & small strokes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) Cumbersland Md							
21. I certify that (I) (this hospital) attended the deceased from 7/9/60 19____, to 7/21/60 19____, that (I) (we) last saw the deceased alive on 7/20/60 , and that death occurred 7:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Richard J. Williams				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS	
22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-23-60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumbersland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumbersland, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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TO THE HONORABLE CHIEF OF BUREAU

DEPARTMENT OF THE ARMY

WASHINGTON, D.C.

DEPT.

ARMY

OFFICE OF THE CHIEF

OF THE BUREAU

U.S.A.

ARMY

OFFICE OF THE CHIEF

OF THE BUREAU

WASHINGTON, D.C.

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(1)

RECEIVED AT THE OFFICE OF THE CHIEF OF THE BUREAU

DEPARTMENT OF THE ARMY

WASHINGTON, D.C.

OFFICE OF THE CHIEF

OF THE BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9 Film 6267 7-20-60 et CERTIFICATE OF DEATH									
7521					Reg. Dist. No. 07514				
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 29 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART					d. STREET ADDRESS 562 NATIONAL HIGHWAY (LAVALLE)				
3. NAME OF DECEASED (Type or print) First DAISY Middle Marie Last DICK					4. DATE OF DEATH Month JULY Day 10 Year 19 60				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/01		9. AGE (In years, months, days, hours, minutes) 59 years 11 months 19 days 19 hours 19 minutes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA, Swan Quarter			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID MIDYETTE					14. MOTHER'S MAIDEN NAME Betty M. Berry				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		INFORMANT PTS CHART			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-1 , 19 58 , to 7-10 , 19 60 , that I last saw the deceased alive on 7-10 , 19 60 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE L. Brings			ADDRESS (Street, city or town, state) 576 Greene St						
PHYSICIAN'S NAME (Type) DR. L. BRINGS M.D.			DATE SIGNED 7-11-60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7/12/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery			22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland					24a. REC'D BY REGISTRAR Jul 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

CERTIFICATE OF DEATH

1951



DECEASED NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESS: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF CLERK: [illegible]

SIGNATURE OF CHURCH CLERK: [illegible]

SIGNATURE OF MINISTER: [illegible]

SIGNATURE OF RABBI: [illegible]

SIGNATURE OF PRIEST: [illegible]

SIGNATURE OF BISHOP: [illegible]

SIGNATURE OF ARCHBISHOP: [illegible]

SIGNATURE OF PRIMATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GREGORY Middle TRENT Last DOBYNS			4. DATE OF DEATH Month July Day 3 , Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1960		9. AGE (In years last birthday) 0 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Lloyd A. Dobyns Jr.			14. MOTHER'S MAIDEN NAME Patricia Parker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lloyd A. Dobyns Jr. Address Cumberland, Md. 317 Pulaski St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION DUE TO LARYNGOSPASM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH SUDDEN SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ENLARGED THYMUS, ADRENAL HYPOPLASIA, MARKED					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JULY 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/60	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.			24a. REC'D BY REGISTRAR DATE JUL 7 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

Reg. Dist. No.

7523

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Flintstone, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital D.O.A.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MYERS</u> Last <u>DONAHOE</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1891</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clothing Worker, Pajama Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Midlothian, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Alfretta Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-12-3312</u>			
17. INFORMANT <u>John Donahue, Rt #2, Flintstone, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 19, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burke H. Montecant</u> ADDRESS <u>23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7524
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07517

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/6/1877	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 445 Cumberland Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle W. Last Donnelly		4. DATE OF DEATH Month July Day 8, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Webster		14. MOTHER'S MAIDEN NAME Anna C. Voelkel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Pulmonary Hypostasis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Deterioration		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/5/60 to 7/8/60 , 19 60 , that (I) (we) last saw the deceased alive on 7/8/60 , 19 60 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 7/9/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR JUL 13 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7525

07518

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CUMBERLAND, MD. b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 24 DAYS			
d. NAME OF DECEASED (If in hospital, give street address) MEMORIAL & WARWICK AVE.				d. STREET ADDRESS 211 CECELIA STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First ADOLPH		Middle		Last DUERR	
4. DATE OF DEATH		Month JULY		Day 22		Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-31-1892		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DUERR				14. MOTHER'S MAIDEN NAME BARBARA REIBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Coronary Heart disease DUE TO BRONCHIAL ASTHMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Bleeding Duodenal Ulcer DUE TO 241X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) you 1 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH you 1 1/2 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/28 to 7/22 , 19 60 , that (I) last saw the deceased alive on 7/22 19 60 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE George M. Simons				22b. DATE SIGNED 7/22/60		22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS	
22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF 7/23/60		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Allen Inc.				25a. REC'D BY REGISTRAR DATE JUL 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	



1952

CERTIFICATE OF DEATH

MADE AT THE DEPARTMENT OF HEALTH
IN ACCORDANCE WITH THE ACT OF CONGRESS OF 1903

DECEASED

DATE

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

CAUSE

DATE

TIME

PLACE

DATE

NAME

NAME

10

10

[Faint, illegible text at the bottom of the page, possibly a signature or additional notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7526

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07519

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If outside corporate limits, write RURAL and give nearest town) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle AGNES Last EASTON		4. DATE OF DEATH Month JULY Day 13 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 24, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMANUEL EVERSOLE		14. MOTHER'S MAIDEN NAME JENNIE SOWDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Aden-Sike Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Complicated Heart Block (c) Aden-Sike Syndrome		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13, 1960 to July 13, 1960 , that (I) we last saw the deceased alive on July 13, 1960 and that death occurred at 12:30 PM from the cause and on the date stated above.			
22a. SIGNATURE G. Overton Himmelwright		22b. DATE SIGNED 7/14/60	
22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Fries			

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CERTIFICATE OF DEATH

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CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07520
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b XXXX 5 Hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL, CUMBERLAND, MD.				d. STREET ADDRESS 25 Arch St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOY Middle A. Last EVANS				4. DATE OF DEATH Month July Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-1-12	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME EDWARD PORTMESS				14. MOTHER'S MAIDEN NAME RENA CURRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT SACRED HEART HOSP..CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION, MARKED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC FAILURE DUE TO (c) RHEUMATIC FEVER				INTERVAL BETWEEN ONSET AND DEATH 4 Hrs. 11 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JULY 22, 1960			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				24a. REC'D BY REGISTRAR DATE JUL 26 1960		24b. REGISTRAR'S SIGNATURE <i>William B. Howard</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7528

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07521

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 Park Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FANNA Middle GRAYCE Last FEESER				4. DATE OF DEATH Month July Day 11 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1882	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
13. FATHER'S NAME Edwin Albright				14. MOTHER'S MAIDEN NAME Nancy Albright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Charles A. Feeser				18. ADDRESS 312 Park Street Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coccyus thrombois Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerosis DUE TO (c) Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Daddy INTERVAL BETWEEN ONSET AND DEATH 7-11-60							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9-21-60 to 7-11-60 , that (I) was last saw the deceased alive on 7-1-60 and that death occurred at 11:50 P from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 7-11-60			
22c. PHYSICIAN'S NAME (Type) W. F. Williams M.D.				22d. ADDRESS 122 So. Center Street Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/14/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum	
23d. LOCATION (City, town, or county) (State) Cumberland, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE JUL 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

7553

(4)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

CERTIFICATE OF DEATH

Reg. Dist. No.

7529

1. PLACE OF DEATH a. COUNTY MARYLAND ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 10 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GARLOCK MARY ROSE				4. DATE OF DEATH Month JULY Day 5 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1922	
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 6 Days 20 Hours 15 Min.		11. IF UNDER 24 HRS. Months 6 Days 20 Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME TONY NATALLY (DECEASED)				14. MOTHER'S MAIDEN NAME JOSEPHINE LARRIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---			
17. INFORMANT PATIENTS CHART				Address ---			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Retrolentular Area Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epithelioid in type DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1960 to July 5, 1960 , that I last saw the deceased alive on July 4, 1960 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler				ADDRESS (Street, city or town, state) 43 Greene St., Cumberland, Md.			
PHYSICIAN'S NAME (Type) Blane M. Schindler, M.D.				DATE SIGNED 7/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF 5/7/60			
22c. NAME OF CEMETERY OR CREMATORY Sunset Manor Pk.				22d. LOCATION (City, town, or county) (State) Cumberland Md			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Comb. Md.				24a. REC'D BY REGISTRAR JUL 7 '60			
ADDRESS ---				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07523

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE St. Petersburg, Fla b. COUNTY 48X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3053 Upton Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith E. Daisy Gowans		4. DATE OF DEATH Month 7/ Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Duckworth		14. MOTHER'S MAIDEN NAME Emma Greene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Record- Sacred Heart Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Decomposition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-24-1960 to 7-23-1960 that (I) (we) last saw the deceased alive on 7-23-1960 and that death occurred at 10 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. James J. Johnson Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. James J. Johnson Jr.		22d. ADDRESS 1691 West St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7/25/1960	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) St. Petersburg, Florida.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR DATE JUL 26 '60	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	



7531

CERTIFICATE OF DEATH

Reg. Dist. No. 07524

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 02 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 604 Greene St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle Joseph Last Grabenstein		4. DATE OF DEATH Month 7 Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-93
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk,		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office Maryland, Allegany Co.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Julius Grabenstein		14. MOTHER'S MAIDEN NAME Mary Martz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Informant Address Cumb. Md. Mrs. Mary C. Grabenstein 604 Greene St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO 410X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary Arteriosclerosis; myocardial disease DUE TO 9 yrs. (c) Mitral stenosis and insufficiency ? ?			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural effusion, right; Complete anuria.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 16, 1951 to July 10, 1960 that I last saw the deceased alive on July 10, 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/12/60			
ACTUAL SIGNATURE Dr. S. M. Jacobson M.D.		PHYSICIAN'S NAME (Type) 50 Pershing St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/13/60	22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. House

DECLARATION OF AFRICAN

1. I, the undersigned,

do hereby declare

that I am a

citizen of the

State of

and that I am

qualified to

serve in the

army of the

United States

of America

and that I

am a member

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

7532

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07525

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle P. Last HALLER				4. DATE OF DEATH Month JULY Day 13 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-1886		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic				10b. KIND OF BUSINESS OR INDUSTRY K.S. Inc Co		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANKLIN P. HALLER				14. MOTHER'S MAIDEN NAME BERTIE COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) No		16. SOCIAL SECURITY NO. 214-07-1018		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X DUE TO Chronic Hypertensive Cardio Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Since Jan '60 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4-1960 to 7-13-1960 that (I) was last saw the deceased alive on 7-13-1960 and that death occurred at 3:19 PM from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 7-14-60		22c. PHYSICIAN'S NAME (Type) DR. W.F.WILLIAMS	
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pl.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md				25a. REC'D BY REGISTRAR DATE JUL 18 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Knease	

07532

DEPARTMENT OF HEALTH
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1933

(M)

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
TIME OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF PHYSICIAN
SIGNATURE OF CLERK

10-17-33

10-17-33

10-17-33

10-17-33

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10-17-33

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07526

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 6/22/60			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Mae Last Hartman				4. DATE OF DEATH Month July Day 2 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/2/1878	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ernest Hartman				14. MOTHER'S MAIDEN NAME Wilhelmina Dehler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT P.O.Box 599 Address Cumberland, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Valvular Heart Disease DUE TO (c) Senile Deterioration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/22/60 19 7/2/60 , that (I) (we) last saw the deceased alive on 7/1/60 19 7/2/60 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James E. McLean				22b. DATE SIGNED 7/2/60			
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/5/60			
23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery				23d. LOCATION (City, town, or county) (State) Cumberland Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				25a. REC'D BY REGISTRAR DATE JUL 5 '60			
25b. REGISTRAR'S SIGNATURE James E. McLean							

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7733



Allegheny

Allegheny

Allegheny

Quincy

6/2/60

Quincy

815 Snyder Avenue

Allegheny County Jail

6/2/60

July

Harmon

1960

Fluorine

32

6/2/60

White

Female

U. S. A.

Registered Nurse

Allegheny County Jail

Edward Hartman

Allegheny County Jail

Allegheny County Jail

6/2/60

6/2/60

6/2/60

6/2/60

Dr. James H. McMan

Allegheny

St. Louis

6/2/60

Allegheny County Jail

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Frederick ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.				d. STREET ADDRESS 1313 So. Loudoun St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle Franklin Last HIMES				4. DATE OF DEATH Month July Day 15 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 23, 1883		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carman				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Prince Albert Himes				14. MOTHER'S MAIDEN NAME Jane West					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 710-09-5010		17. INFORMANT Address Winchester, Va. Mrs. Fred L. Himes 1311 So. Loudoun St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH Sudden ? </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Benedict Skitarelic M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/15/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		22d. LOCATION (City, town, or county) (State) Brownsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUL 18 1960		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE AT DEATH		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1950		NEW YORK CITY	
RESIDENCE		CITY		COUNTY		STATE		MARRIAGE		MANNER OF DEATH	
1234 5th Ave		NEW YORK		NEW YORK		NEW YORK		MARRIED		NATURAL	
A. FIRST ADDRESS		B. SECOND ADDRESS		C. THIRD ADDRESS		D. FOURTH ADDRESS		E. FIFTH ADDRESS		F. SIXTH ADDRESS	
1234 5th Ave		1234 5th Ave		1234 5th Ave		1234 5th Ave		1234 5th Ave		1234 5th Ave	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		RELIGION		POLITICAL PARTY	
JAN 15 1905		NEW YORK		HIGH SCHOOL		CLOCK REPAIRER		CATHOLIC		DEMOCRAT	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER'S SIGNATURE		EXAMINER'S SIGNATURE		EXAMINER'S SIGNATURE		EXAMINER'S SIGNATURE	
JAN 16 1950		NEW YORK		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	
DATE OF INTERMENT		PLACE OF INTERMENT		INTERMENT SIGNATURE		INTERMENT SIGNATURE		INTERMENT SIGNATURE		INTERMENT SIGNATURE	
JAN 17 1950		NEW YORK		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, ONLY.

NOTARY PUBLIC

NOTARY PUBLIC

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7535

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07528

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Columbia St.		d. STREET ADDRESS 303 Columbia, ST.	
3. NAME OF DECEASED (Type or print) First MARGARET Middle HOBAN Last HOBAN		4. DATE OF DEATH 7/1/1960 Month 7 Day 1 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept, 6th. 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Nikep, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sullivan		14. MOTHER'S MAIDEN NAME Ann Brennen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Hoban		Address Cumberland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15 1960 to July 2 1960 , that (I) (we) last saw the deceased alive on July 1 1960 , and that death occurred at 4 M, from the causes and on the date stated above.			
22a. SIGNATURE B. M. Schindler		22b. DATE SIGNED 7/1/60	
22c. PHYSICIAN'S NAME (Type) B. M. Schindler		22d. ADDRESS 43 Everett Ave., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/5/1960	23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery	23d. LOCATION (City, town, or county) (State) Cumberland, MD.
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25. REC'D BY REGISTRAR JUL 6 '60	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

07528

CHIEF OF BUREAU

1032

Allegany

Barryland

Allegany

Barryland

Barryland

303 Columbia St.

303 Columbia St.

W. 11/1930

LOAN

MARSHALL

Sept. 1933

Sept. 1933

U.S.A.

Marshall, Md.

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7568
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07529

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle B. Last Hoover		4. DATE OF DEATH Month July Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 26, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Sylvia Keller, RFD 1, Frostburg, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hrs years 2 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1956 to July 23, 1960 , that (I) (we) lost the deceased alive on July 23, 1960 , and that death occurred at 9p M, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.		22d. ADDRESS Lonaconing Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/60	
23c. NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery		23d. LOCATION (City, town, or county) (State) Vale Summit Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR JUL 28 '60	
ADDRESS Lonaconing, Maryland		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7536
CERTIFICATE OF DEATH

Reg. Dis. No. 07530

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 60 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 900 E. Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Hough Last Hough		4. DATE OF DEATH Month July Day 24 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Waterford, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hector Hough		14. MOTHER'S MAIDEN NAME Jane E. Shoemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-09-9856	
17. INFORMANT Mildred Payne		Address 900 Oldtown Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7/22/60 19 60 to 7/24/60 , that I last saw the deceased alive on 7/24/60 and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/25/60			
ACTUAL SIGNATURE Richard J. Williams M.D.			
PHYSICIAN'S NAME (Type) Richard J. Williams 122 S. Centre St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-27-60	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE JUL 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraw

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 5,6,7 FilmG267 7-28-60 et

07531
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN lb <u>70 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>226 East Main</u>			d. STREET ADDRESS <u>226 East Main</u>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Hunter</u> Last <u>Sr.</u>			4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-1863</u>	9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Staffordshire, England</u>	
13. FATHER'S NAME <u>Thomas Hunter</u>			14. MOTHER'S MAIDEN NAME <u>Mary Foley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward L. Hunter, 226 E. Main, Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>540.0</u> IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage, Massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peptic Ulcer</u> DUE TO (c) <u>(?)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5-10 Min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>(County)</u>	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>July 19, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Reub H. Montesant</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krouse</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, AND TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07532

Reg. Dist. No.

7537

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>19 Harrison Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE RENNETTI JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>July 2 19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1888</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Capon Bridge, W.Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Milton Barrow</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Gossawick</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bedford Road</u> <u>Charles Shanholtz</u> <u>Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>---</u>								INTERVAL BETWEEN ONSET AND DEATH <u>15-20 Min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>JULY 2, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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7538

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07533

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS BOX 345		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First A Middle KLINE Last		4. DATE OF DEATH Month JULY Day 26 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 25, 1893	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 2 Days 1 Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Orchard Worker		11. BIRTHPLACE (State or foreign country) W.VA. Morgan County	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN KLINE				14. MOTHER'S MAIDEN NAME AMANDA RAINER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W. W. I 232-10-2462		17. INFORMANT Mrs John A. Kline, c/o Postmaster Paw Paw, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Coronary Artery Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7-19-60 to 7-26-60 that (I) (we) last saw the deceased alive on 7-26 19 60 and that death occurred at 12:05 PM the causes and on the date stated above.							
22a. SIGNATURE W.F. Williams				22b. DATE SIGNED 7-27-60		22c. PHYSICIAN'S NAME (Type) W.F. WILLIAMS	
22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REPOSING (Specify) BURIAL		23b. DATE THEREOF 7/29/60		23c. NAME OF CEMETERY OR CREMATORY Camp Hill Cem.		23d. LOCATION (City, town, or county) (State) Paw Paw, (Morgan) W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE PARKS Funeral Home Berkeley Springs, W. Va.				25a. REC'D BY REGISTRAR AUG 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

07538

CYRILLIC OF DEATH

7538

M

ALLEGY

WEST VIRGINIA

LIBERTY

6 DAYS

PAW PAW

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

BOX 115

JOHN

KLINE

JULY

MAY 25, 1963

PAID BY WHITE

ORCHARD WORKER

LABORER

W.V.A. MORGAN COUNTY, W.V.A.

ARMED RAIDER

JOHN KLINE

SEE-10-2000

Yes W. V. I

THE JOHN A. KLINE, JR. & JOHN A. KLINE, JR. & JOHN A. KLINE, JR.

1

PAW PAW (MORGAN) V. VA.

Camp Hill Co.

BUNNELL V/28/60

PAW PAW (MORGAN) V. VA. & JOHN A. KLINE, JR. & JOHN A. KLINE, JR.

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07534

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 22 HRS. 40 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) First Infant Middle Last LEASE				4. DATE OF DEATH Month JULY Day 16 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1960	
9. AGE (In years lost birthday) yrs.		10. AGE (In years lost birthday) yrs.		11. AGE (In years lost birthday) yrs.		12. AGE (In years lost birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME COLIN DALE LEASE				14. MOTHER'S MAIDEN NAME BARBARA ELLEN DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to July 16, 1960 , that (I) (we) last saw the deceased alive on July 16, 1960 , and that death occurred at 7:00 AM from the causes and on the date stated above.							
22a. SIGNATURE W. R. Hoges				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) W. R. Hoges				22d. ADDRESS Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 16, 1960			
23c. NAME OF CEMETERY OR CREMATORY Ft Ashby				23d. LOCATION (City, town, or county) (State) Ft Ashby, W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Geo. A. Chambers				25a. REC'D BY REGISTRAR JUL 25 '60			
ADDRESS Keyser, W. Va.				25b. REGISTRAR'S SIGNATURE Charles S. Hume			

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(1)

ALLIANCE

WEEDING

25 JUL 1940

PATTERSON WOOD

WEST VIRGINIA

MATERIAL

EXHIBIT A BARRIET W. 11

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WHITE

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COIN DATE 1940

BARBARA ELLER DAVIS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07535
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 472 Winifred Rd.				d. STREET ADDRESS Box 472 Winifred Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle DEWEY Last LECHLITER				4. DATE OF DEATH Month July Day 20, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1899		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) Mineral Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emmor T. Lechlitter				14. MOTHER'S MAIDEN NAME Mary C. Largent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-07-0699		17. INFORMANT Mrs. Myrtle Lechlitter Address Cumb. Md. Rd. Box 472 Winifred			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION DUE TO 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STRANGULATION (c) HANGING						INTERVAL BETWEEN ONSET AND DEATH 10-15 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED JULY 20, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUL 22 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7540

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. BIRTH DATE 1880		6. BIRTH PLACE Maryland		7. MARRIAGE DATE 1905		8. MARRIAGE PLACE Baltimore	
9. DECEASED DATE 1945		10. DECEASED TIME 10:00 AM		11. DECEASED PLACE Home		12. DECEASED CAUSE Heart Disease		13. DECEASED MANNER Natural		14. DECEASED OCCASION None		15. DECEASED SIGNATURE J. H. Harris		16. DECEASED ADDRESS 123 Main St, Baltimore	
17. DECEASED OCCUPATION None		18. DECEASED EDUCATION None		19. DECEASED RELIGION None		20. DECEASED POLITICAL PARTY None		21. DECEASED SOCIAL SECURITY None		22. DECEASED VETERAN STATUS None		23. DECEASED MILITARY SERVICE None		24. DECEASED NAVY SERVICE None	
25. DECEASED AIR FORCE SERVICE None		26. DECEASED MARINE SERVICE None		27. DECEASED ARMY SERVICE None		28. DECEASED NAVY SERVICE None		29. DECEASED AIR FORCE SERVICE None		30. DECEASED MARINE SERVICE None		31. DECEASED ARMY SERVICE None		32. DECEASED NAVY SERVICE None	
33. DECEASED AIR FORCE SERVICE None		34. DECEASED MARINE SERVICE None		35. DECEASED ARMY SERVICE None		36. DECEASED NAVY SERVICE None		37. DECEASED AIR FORCE SERVICE None		38. DECEASED MARINE SERVICE None		39. DECEASED ARMY SERVICE None		40. DECEASED NAVY SERVICE None	
41. DECEASED AIR FORCE SERVICE None		42. DECEASED MARINE SERVICE None		43. DECEASED ARMY SERVICE None		44. DECEASED NAVY SERVICE None		45. DECEASED AIR FORCE SERVICE None		46. DECEASED MARINE SERVICE None		47. DECEASED ARMY SERVICE None		48. DECEASED NAVY SERVICE None	
49. DECEASED AIR FORCE SERVICE None		50. DECEASED MARINE SERVICE None		51. DECEASED ARMY SERVICE None		52. DECEASED NAVY SERVICE None		53. DECEASED AIR FORCE SERVICE None		54. DECEASED MARINE SERVICE None		55. DECEASED ARMY SERVICE None		56. DECEASED NAVY SERVICE None	
57. DECEASED AIR FORCE SERVICE None		58. DECEASED MARINE SERVICE None		59. DECEASED ARMY SERVICE None		60. DECEASED NAVY SERVICE None		61. DECEASED AIR FORCE SERVICE None		62. DECEASED MARINE SERVICE None		63. DECEASED ARMY SERVICE None		64. DECEASED NAVY SERVICE None	
65. DECEASED AIR FORCE SERVICE None		66. DECEASED MARINE SERVICE None		67. DECEASED ARMY SERVICE None		68. DECEASED NAVY SERVICE None		69. DECEASED AIR FORCE SERVICE None		70. DECEASED MARINE SERVICE None		71. DECEASED ARMY SERVICE None		72. DECEASED NAVY SERVICE None	
73. DECEASED AIR FORCE SERVICE None		74. DECEASED MARINE SERVICE None		75. DECEASED ARMY SERVICE None		76. DECEASED NAVY SERVICE None		77. DECEASED AIR FORCE SERVICE None		78. DECEASED MARINE SERVICE None		79. DECEASED ARMY SERVICE None		80. DECEASED NAVY SERVICE None	
81. DECEASED AIR FORCE SERVICE None		82. DECEASED MARINE SERVICE None		83. DECEASED ARMY SERVICE None		84. DECEASED NAVY SERVICE None		85. DECEASED AIR FORCE SERVICE None		86. DECEASED MARINE SERVICE None		87. DECEASED ARMY SERVICE None		88. DECEASED NAVY SERVICE None	
89. DECEASED AIR FORCE SERVICE None		90. DECEASED MARINE SERVICE None		91. DECEASED ARMY SERVICE None		92. DECEASED NAVY SERVICE None		93. DECEASED AIR FORCE SERVICE None		94. DECEASED MARINE SERVICE None		95. DECEASED ARMY SERVICE None		96. DECEASED NAVY SERVICE None	
97. DECEASED AIR FORCE SERVICE None		98. DECEASED MARINE SERVICE None		99. DECEASED ARMY SERVICE None		100. DECEASED NAVY SERVICE None		101. DECEASED AIR FORCE SERVICE None		102. DECEASED MARINE SERVICE None		103. DECEASED ARMY SERVICE None		104. DECEASED NAVY SERVICE None	
105. DECEASED AIR FORCE SERVICE None		106. DECEASED MARINE SERVICE None		107. DECEASED ARMY SERVICE None		108. DECEASED NAVY SERVICE None		109. DECEASED AIR FORCE SERVICE None		110. DECEASED MARINE SERVICE None		111. DECEASED ARMY SERVICE None		112. DECEASED NAVY SERVICE None	
113. DECEASED AIR FORCE SERVICE None		114. DECEASED MARINE SERVICE None		115. DECEASED ARMY SERVICE None		116. DECEASED NAVY SERVICE None		117. DECEASED AIR FORCE SERVICE None		118. DECEASED MARINE SERVICE None		119. DECEASED ARMY SERVICE None		120. DECEASED NAVY SERVICE None	
121. DECEASED AIR FORCE SERVICE None		122. DECEASED MARINE SERVICE None		123. DECEASED ARMY SERVICE None		124. DECEASED NAVY SERVICE None		125. DECEASED AIR FORCE SERVICE None		126. DECEASED MARINE SERVICE None		127. DECEASED ARMY SERVICE None		128. DECEASED NAVY SERVICE None	
129. DECEASED AIR FORCE SERVICE None		130. DECEASED MARINE SERVICE None		131. DECEASED ARMY SERVICE None		132. DECEASED NAVY SERVICE None		133. DECEASED AIR FORCE SERVICE None		134. DECEASED MARINE SERVICE None		135. DECEASED ARMY SERVICE None		136. DECEASED NAVY SERVICE None	
137. DECEASED AIR FORCE SERVICE None		138. DECEASED MARINE SERVICE None		139. DECEASED ARMY SERVICE None		140. DECEASED NAVY SERVICE None		141. DECEASED AIR FORCE SERVICE None		142. DECEASED MARINE SERVICE None		143. DECEASED ARMY SERVICE None		144. DECEASED NAVY SERVICE None	
145. DECEASED AIR FORCE SERVICE None		146. DECEASED MARINE SERVICE None		147. DECEASED ARMY SERVICE None		148. DECEASED NAVY SERVICE None		149. DECEASED AIR FORCE SERVICE None		150. DECEASED MARINE SERVICE None		151. DECEASED ARMY SERVICE None		152. DECEASED NAVY SERVICE None	
153. DECEASED AIR FORCE SERVICE None		154. DECEASED MARINE SERVICE None		155. DECEASED ARMY SERVICE None		156. DECEASED NAVY SERVICE None		157. DECEASED AIR FORCE SERVICE None		158. DECEASED MARINE SERVICE None		159. DECEASED ARMY SERVICE None		160. DECEASED NAVY SERVICE None	
161. DECEASED AIR FORCE SERVICE None		162. DECEASED MARINE SERVICE None		163. DECEASED ARMY SERVICE None		164. DECEASED NAVY SERVICE None		165. DECEASED AIR FORCE SERVICE None		166. DECEASED MARINE SERVICE None		167. DECEASED ARMY SERVICE None		168. DECEASED NAVY SERVICE None	
169. DECEASED AIR FORCE SERVICE None		170. DECEASED MARINE SERVICE None		171. DECEASED ARMY SERVICE None		172. DECEASED NAVY SERVICE None		173. DECEASED AIR FORCE SERVICE None		174. DECEASED MARINE SERVICE None		175. DECEASED ARMY SERVICE None		176. DECEASED NAVY SERVICE None	
177. DECEASED AIR FORCE SERVICE None		178. DECEASED MARINE SERVICE None		179. DECEASED ARMY SERVICE None		180. DECEASED NAVY SERVICE None		181. DECEASED AIR FORCE SERVICE None		182. DECEASED MARINE SERVICE None		183. DECEASED ARMY SERVICE None		184. DECEASED NAVY SERVICE None	
185. DECEASED AIR FORCE SERVICE None		186. DECEASED MARINE SERVICE None		187. DECEASED ARMY SERVICE None		188. DECEASED NAVY SERVICE None		189. DECEASED AIR FORCE SERVICE None		190. DECEASED MARINE SERVICE None		191. DECEASED ARMY SERVICE None		192. DECEASED NAVY SERVICE None	
193. DECEASED AIR FORCE SERVICE None		194. DECEASED MARINE SERVICE None		195. DECEASED ARMY SERVICE None		196. DECEASED NAVY SERVICE None		197. DECEASED AIR FORCE SERVICE None		198. DECEASED MARINE SERVICE None		199. DECEASED ARMY SERVICE None		200. DECEASED NAVY SERVICE None	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07536

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 16 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERMAN ALBERT LITTLE		4. DATE OF DEATH July 31 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Little		14. MOTHER'S MAIDEN NAME Mary Ann Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-07-9571	
17. INFORMANT Mrs. Mary P. Little		18. ADDRESS 516 Fort Avenue, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH % 5 Hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> J		DATE SIGNED AUG. " 2, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/60	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE AUG 3 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

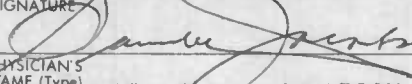

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7542

07537

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 421 FURNACE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARTHA E. LOGSDON				4. DATE OF DEATH Month Day Year JULY 11 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 7, 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY NICHOL				14. MOTHER'S MAIDEN NAME ANNA GEARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture esophageal varices DUE TO (c) Cirrhosis of liver INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs. ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Repeated ascites for several years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 9 19 60 to July 11 19 60 that (I) (we) last saw the deceased alive on July 11 19 60 and that death occurred at 11:30 PM the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 7/12/60		22c. PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON	
22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1960		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 15 60 DATE	
				25b. REGISTRAR'S SIGNATURE 			

85537

CERTIFICATE OF DEATH

1942

ALLIANCE

WILLIAM

CHURCH

CHURCH

CHURCH

101 TOWNE STREET

MEMORIAL HOSPITAL

WILLIAM & MARY ANN

LEWIS

WILLIAM

WILLIAM T. WILSON

WILLIAM T. WILSON

WILLIAM

WILLIAM

WILLIAM

WILLIAM

MEMORIAL HOSPITAL, CHURCH, WILSON

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CERTIFICATE OF DEATH

07538
Reg. Dist. No.

7543

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. STREET ADDRESS 517 HENDERSON AVE.			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle Raymond Last MCKNIGHT				4. DATE OF DEATH Month JULY Day 4 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland, U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES MCKNIGHT (DECEASED)				14. MOTHER'S MAIDEN NAME REGINA Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-5059		INFORMANT 13313 Dauphine St., Md. Mrs. M. DeSales Becker Silver Springs,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brachyogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/3 , 19 60 to 7/4 , 19 60 , that I last saw the deceased alive on 7/3 , 19 60 , and that death occurred at 6:19A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. CENTRE ST. CUMBERLAND, MD. DATE SIGNED 7/5/60							
ACTUAL SIGNATURE Leo H. Ley, Jr. M.D.							
PHYSICIAN'S NAME (Type) LEO H. LEY, JR. 456 N. CENTRE ST. CUMBERLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/60		22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07282

CERTIFICATE OF DEATH

7643

07282
7643
CERTIFICATE OF DEATH

7570

CERTIFICATE OF DEATH

07539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN TB <u>25yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 Beall St. (residence)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SADIE</u> <u>LILLIAN</u> <u>MEEKHAM</u>				4. DATE OF DEATH Month Day Year <u>7</u> <u>4</u> <u>19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1894</u>	9. AGE (In years last birthday) <u>66 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>St. Regis Falls, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hofer Stafford Meekham</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Miss Pearl Neff, 32 Beall St.,</u>		Address <u>Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Pneumonia Endocarditis</u> DUE TO (c) <u>6 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>July 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>60</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. M. Lane</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Frostburg July 5</u> <u>Md. 1960</u>			
PHYSICIAN'S NAME (Type) <u>W. M. Lane M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bulah H. Montanant</u>				24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Jul 11 '60</u>	

CERTIFICATE OF DEATH

1950

05250



Blank form area with faint horizontal lines and vertical grid lines, containing very faint, illegible text.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 7545 CERTIFICATE OF DEATH 07541											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 8/8/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary					d. STREET ADDRESS 145 Bedford Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Augusta Middle M. Last Miller					4. DATE OF DEATH Month July Day 1, Year 1960						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/18/1870		9. AGE (In years lost birthday) 89 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania, Bedford Co.			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Washington Miller					14. MOTHER'S MAIDEN NAME Catherine Fisher						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) General Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Deterioration										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 8/8/56 19 56 , to 7/1/60 19 60 , that (I) (we) last saw the deceased alive on 7/1/60 19 60 , and that death occurred at 11:55 PM , from the causes and on the date stated above.											
22a. SIGNATURE James E. McLean					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/2/60				
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean					22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/60		23c. NAME OF CEMETERY OR CREMATORY Fellowship Cemetery			23d. LOCATION (City, town, or county) (State) Bedford County, Pennsylvania				
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland					25a. REC'D BY REGISTRAR DATE JUL 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Haas				



1943

CERTIFICATE OF DEATH

112553

Allegany

Marshall

Allegany

West Virginia

8/8/55

Charleston

Allegany County Infirmary

The Hospital Street

Augusta

M.

Miller

July

60

White

Female

10/13/1970

39

Noted: See Section Assistant

West Virginia, U. S. A.

Marshall County

Charleston

Charleston, W. Va.

None

Allegany County Infirmary Records

[Faint, illegible handwritten text]

7/1/60

8/8/55

7/1/60

Dr. James E. Mohr

Dr. James E. Mohr

Dr. James E. Mohr, Charleston, W. Va.

Dr. James E. Mohr, Charleston, W. Va.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

M

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7546 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Memorial Hospital			d. STREET ADDRESS 827 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Horace G. MILLER			4. DATE OF DEATH Month JULY Day 27 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1867		9. AGE (In years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Berkley Springs, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT David W. Miller Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) —					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) —		20g. (County) —		20h. (State) —	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JULY 27, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery	
22d. LOCATION (City, town, or county) Martinsburg, W. Va.		(State) —			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS 117 Frederick St. Cumb. Md.		24a. REC'D BY REGISTRAR DATE AUG 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 7547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07543

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 hour			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 512 Hill Street			
3. NAME OF DECEASED (Type or print) ALBERT FRANKLIN MORRIS Jr.				4. DATE OF DEATH July 17 19 60			
5. SEX Male		6. COLOR OR RACE Brown		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1901	
9. AGE (in years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Albert F. Morris				14. MOTHER'S MAIDEN NAME Annie Robinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 705-05-8047			
17. INFORMANT Mrs. Ruth Brown				Address Hickory, North Carolina			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/20/60			
22c. NAME OF CEMETERY OR CREMATORY Sumner Cemetery				22d. LOCATION (City, town, or country) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR JUL 20 '60			
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

0753

1001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
OF TEXAS

County of _____

City of _____

State of _____

Decedent's name _____

Age _____

Sex _____

Residence _____

Place of death _____

100

July 17

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

7548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL--DOA		d. STREET ADDRESS 766 Maryland Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLIVE Middle MUELLER Last MUELLER		4. DATE OF DEATH Month July Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 6 Days 12	IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Wardensville, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William E. Shumaker		14. MOTHER'S MAIDEN NAME Rachael Bollinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Chas. Mueller, Greenspring, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC DISEASE DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 30 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JULY 19, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 22, 1960	
22c. NAME OF CEMETERY OR CREMATORY SULPHUR SPRINGS		22d. LOCATION (City, town, or county) (State) KIFEK, ALLEGANY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE PARKS F. HONE, C.E.		ADDRESS BERKELEY SPRINGS, W. VA.	
24a. REC'D BY REGISTRAR JUL 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7549

07545

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 12 QUEEN CITY PAVEMENT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle J. Last MURRAY				4. DATE OF DEATH Month JULY Day 3 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1902		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rest. Wkr.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA MT. NEBO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES SWANGER				14. MOTHER'S MAIDEN NAME LUCY SIRBAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-16-6108		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast - Bilateral DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phen to Heart						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1954 to July 1960 that (I) (we) last saw the deceased alive on July 3, 1960 , and that death occurred at 7:55 PM , from the cause and on the date stated above.							
22a. SIGNATURE <i>John J. Hafer</i>				22b. DATE July 5, 1960		22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT	
22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/60	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

05743

CERTIFICATE OF DEATH

7540

ALLIANCE

MARYLAND

ALLIANCE

CORRELAND, MARYLAND

15 GREEN CITY PARKMENT

WALTER A. MARYLAND

MEMORIAL HOSPITAL

1900

JULY

LEWIS

MARY

1900

JUNE 2, 1900

ST. JOHN'S

WEST VIRGINIA

EAST VIRGINIA

ST. JOHN'S

MEMORIAL HOSPITAL, CORRELAND, MARYLAND

Walter A. Mary

Walter A. Mary

123 VIRGINIA ST., GREENSBORO, N.C.

DR. OVERTON HINCHMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUKE		c. LENGTH OF STAY IN 1b 3 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 69 Mullen Ave				d. STREET ADDRESS 69 Mullen Ave			
3. NAME OF DECEASED (Type or print) Baby Girl Myers				4. DATE OF DEATH Month July Day 4 Year 19 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1960	
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Hours 3 Min. 4		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---	
10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? u s a		13. FATHER'S NAME John Ferrell	
14. MOTHER'S MAIDEN NAME Martha J. Myers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address James Poland 69 Mullen Ave. Luke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (450 grams) (6 months) 778 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH --- </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED JULY 4, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY CREMATED AT MEMORIAL HOSPITAL		22d. LOCATION (City, town, or county) (State) CUMBERLAND, ALLEG. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.			
24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

10-X271XV0

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH IN HOME (If death occurred in a home, please indicate the address below.)		DEATH IN OTHER PLACE (If death occurred in a place other than a home, please indicate the place below.)	
PLACE OF DEATH (If death occurred in a home, please indicate the address below.)		PLACE OF DEATH (If death occurred in a place other than a home, please indicate the place below.)	
NAME OF DECEASED (Please print name in full.)		NAME OF DECEASED (Please print name in full.)	
SEX (Please indicate sex.)		SEX (Please indicate sex.)	
AGE (Please indicate age.)		AGE (Please indicate age.)	
DATE OF BIRTH (Please indicate date of birth.)		DATE OF BIRTH (Please indicate date of birth.)	
PLACE OF BIRTH (Please indicate place of birth.)		PLACE OF BIRTH (Please indicate place of birth.)	
OCCUPATION (Please indicate occupation.)		OCCUPATION (Please indicate occupation.)	
MARITAL STATUS (Please indicate marital status.)		MARITAL STATUS (Please indicate marital status.)	
PREVIOUS MEDICAL HISTORY (Please indicate previous medical history.)		PREVIOUS MEDICAL HISTORY (Please indicate previous medical history.)	
CAUSE OF DEATH (Please indicate cause of death.)		CAUSE OF DEATH (Please indicate cause of death.)	
MANNER OF DEATH (Please indicate manner of death.)		MANNER OF DEATH (Please indicate manner of death.)	
SIGNATURE OF EXAMINER (Please indicate signature of examiner.)		SIGNATURE OF EXAMINER (Please indicate signature of examiner.)	
DATE OF EXAMINATION (Please indicate date of examination.)		DATE OF EXAMINATION (Please indicate date of examination.)	
PLACE OF EXAMINATION (Please indicate place of examination.)		PLACE OF EXAMINATION (Please indicate place of examination.)	

7550

CERTIFICATE OF DEATH

Reg. Dist. No.

07547

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 409 BEALL ST. MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 1 409 BEALL ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle NAIRN Last NAIRN				4. DATE OF DEATH Month JULY Day 18 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3,-78	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Kotschenreuther				14. MOTHER'S MAIDEN NAME Catherine Seiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Mrs. John Eeneey Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Pulmonary Embolism DUE TO Partial Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 week DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 minutes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1960 to July 18, 1960 , that I last saw the deceased alive on July 18, 1960 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler M.D. 43 E. ...				DATE SIGNED 7/18/60			
PHYSICIAN'S NAME (Type) DR. BLAINE SCHINDLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/1960		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR JUL 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10521

CERTIFICATE OF DEATH

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

ST. MICHAEL'S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7551

CERTIFICATE OF DEATH

07548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Dist. before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 64 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAE Middle Marie Last NAZELROD		4. DATE OF DEATH Month JULY Day 16 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 16 Hours 19 Min. 60	11. IF UNDER 24 HRS. Months 56 Days 16 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES MCKENZIE		14. MOTHER'S MAIDEN NAME ANNA WEAVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. PATIENT'S CHART	
17. INFORMANT PATIENT'S CHART		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO CARCINOMA OF COLON WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 43 GREENE ST. CUMBERLAND, MD.
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JANUARY , 19 59 , to JULY 16 , 19 60 , that I last saw the deceased alive on JULY 15 , 19 60 , and that death occurred at 8:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 43 GREENE ST. CUMBERLAND, MD. DATE SIGNED 7-16-60 ACTUAL SIGNATURE B. M. Schindler M.D. PHYSICIAN'S NAME (Type) BM M. Schindler, M.D. 43 Greene St., Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/19/60	22c. NAME OF CEMETERY OR CREMATORY Greenville Union Cemetery Nr. Pocahontas, Pennsylvania
22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUL 20 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

11548

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
7552
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07549

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 28 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If in hospital, give street address) MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 324 EMILY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle V. Last NORTHCRAFT				4. DATE OF DEATH Month JULY Day 10 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-1893	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME GEORGE REID				14. MOTHER'S MAIDEN NAME ELLEN FARRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-16-5428		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 145.7 Calculation of Infection DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 23 to July 10 1960 that (I) (we) last saw the deceased alive on July 10 1960, and that death occurred at 9:55 PM from the causes and on the date stated above.							
22a. SIGNATURE DR. OVERTON HIMMELWRIGHT				22b. ADDRESS 133 1/2 Ave, Cumberland, Md.		22c. DATE SIGNED 7/13/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1952

ALLERANY

WIRYLAND

ALLERANY

CUNNINGHAM

22 DAYS

CUNNINGHAM

35, EMERY STREET

1000 W. 10TH AVE.

WEDNESDAY

10TH

WHITE

WHITE

ELIZABETH

GEORGE

22-11-1952

22

James J. Cunningham

James J. Cunningham

3:15 PM

DR. GUYTON H. LAMBERT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7553 CERTIFICATE OF DEATH 07550

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE L OSBOURNE		4. DATE OF DEATH JULY 13 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 27, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) MARYLAND Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WHARTON		14. MOTHER'S MAIDEN NAME ELIZABETH BANKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertension Cerebral DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/13/60 19 to 7/13/60 , that (I) (we) last saw the deceased alive on 7/13/60 19, and that death occurred 8:40 AM from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 7/14/60	
22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-60	
23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR JUL 18 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

(1)

THIS IS A PRELIMINARY REPORT OF THE RESULTS OF THE EXAMINATION OF THE BODY OF THE DECEASED. IT IS NOT TO BE USED AS EVIDENCE IN A COURT OF LAW. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE RETURNED TO THE OFFICE OF ORIGIN UPON REQUEST.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: _____</p>	
<p>AGE: _____</p>	
<p>SEX: _____</p>	
<p>DATE OF DEATH: _____</p>	
<p>PLACE OF DEATH: _____</p>	
<p>CAUSE OF DEATH: _____</p>	
<p>MANNER OF DEATH: _____</p>	
<p>TIME OF DEATH: _____</p>	
<p>PLACE OF BURIAL: _____</p>	
<p>NAME OF FUNERAL HOME: _____</p>	
<p>NAME OF PHYSICIAN: _____</p>	
<p>NAME OF MEDICAL EXAMINER: _____</p>	
<p>SIGNATURE OF MEDICAL EXAMINER: _____</p>	
<p>DATE OF EXAMINATION: _____</p>	
<p>TIME OF EXAMINATION: _____</p>	
<p>PLACE OF EXAMINATION: _____</p>	
<p>NAME OF WITNESS: _____</p>	
<p>SIGNATURE OF WITNESS: _____</p>	
<p>DATE OF SIGNATURE: _____</p>	
<p>TIME OF SIGNATURE: _____</p>	
<p>PLACE OF SIGNATURE: _____</p>	
<p>NAME OF DECEASED: _____</p>	
<p>AGE: _____</p>	
<p>SEX: _____</p>	
<p>DATE OF DEATH: _____</p>	
<p>PLACE OF DEATH: _____</p>	
<p>CAUSE OF DEATH: _____</p>	
<p>MANNER OF DEATH: _____</p>	
<p>TIME OF DEATH: _____</p>	
<p>PLACE OF BURIAL: _____</p>	
<p>NAME OF FUNERAL HOME: _____</p>	
<p>NAME OF PHYSICIAN: _____</p>	
<p>NAME OF MEDICAL EXAMINER: _____</p>	
<p>SIGNATURE OF MEDICAL EXAMINER: _____</p>	
<p>DATE OF EXAMINATION: _____</p>	
<p>TIME OF EXAMINATION: _____</p>	
<p>PLACE OF EXAMINATION: _____</p>	
<p>NAME OF WITNESS: _____</p>	
<p>SIGNATURE OF WITNESS: _____</p>	
<p>DATE OF SIGNATURE: _____</p>	
<p>TIME OF SIGNATURE: _____</p>	
<p>PLACE OF SIGNATURE: _____</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07552

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 7 LINDA WAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JEANNETTE PAXTON				4. DATE OF DEATH Month Day Year JULY 30 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1903		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) BARTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SYMONS				14. MOTHER'S MAIDEN NAME Margaret KIRK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) CARCINOMA OF STOMACH (c) 6 Mo. DUE TO (c) 6 Mo.						INTERVAL BETWEEN ONSET AND DEATH 2-3 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				JULY 30, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/60	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 2 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07553

Reg. Dist. No.

7583

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Flintstone			c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 2 Flintstone,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Upper Flintstone Creek Road				d. STREET ADDRESS Flintstone Creek Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First PAGE Middle EMMITT Last PAXTON				4. DATE OF DEATH Month JULY Day 26 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1892		
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired caretaker			10b. KIND OF BUSINESS OR INDUSTRY Flintstone High		11. BIRTHPLACE (State or foreign country) Grant Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Paxton				14. MOTHER'S MAIDEN NAME Clora Jenkins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 212-12-8437		17. INFORMANT Mrs. Della Paxton, Rt. # 2 Flintstone, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> XX JULY 26, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/60		22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Flintstone, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR AUG 1 '60		
						24b. REGISTRAR'S SIGNATURE Arthur S. Knapp		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

7572

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MORTIMER WAYNE PRYOR				4. DATE OF DEATH Month Day Year 7 17 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-1900		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O Shops				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Blue Rock, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mortimer Pryor				14. MOTHER'S MAIDEN NAME Bessie Osenbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 705-03-4151			
17. INFORMANT Mrs. Ruth Pryor, 913 Nat'l Highway,				Address Lavale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 586X IMMEDIATE CAUSE (a) Acute Dilatation of Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction (c) Cholecystectomy INTERVAL BETWEEN ONSET AND DEATH 2 d. 2 d.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/9 , 19 60 , to 7/17 , 19 60 , that I last saw the deceased alive on 7/17 , 19 60 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Harvat				ADDRESS (Street, city or town, state) 24 W. Mechanic St. Frostburg Md.			
PHYSICIAN'S NAME (Type) FRANK T. HARRAT				DATE SIGNED 7/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/60		22c. NAME OF CEMETERY OR CREMATORY Maple Wood		22d. LOCATION (City, town, or county) (State) New Lexington Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Beriah H. Montesant				24a. REC'D BY REGISTRAR Hafer Funeral Home		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	
23. ADDRESS 23 E. Main, Frostburg, Md.				DATE JUL 25 '60			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11254

CERTIFICATE OF DEATH

11254

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7573 **CERTIFICATE OF DEATH**

07555

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>36 Mill Street</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg</u> STREET ADDRESS (If rural give location) <u>36 Mill Street</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Marcella</u> (Last) <u>Rafferty</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>2</u> , 19 <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 23, 1882</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Scally</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Chambers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. John McDonald, 28 Hill Street, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Several</u> <u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1959</u> , 19....., to <u>July 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>60</u> , and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Wm C Lane</u> M.D. <u>Frostburg Md</u> ADDRESS (Street, city, town, state) <u>Frostburg, Maryland</u> DATE SIGNED <u>July 4 1960</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 5, 1960</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leighty</u> ADDRESS <u>Woodmen, Pennsylvania</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1

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91
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7555
CERTIFICATE OF DEATH
07556

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/8/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinto, Maryland	
f. STREET ADDRESS (Pinto, Md.)		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle V. Last Rawlings		4. DATE OF DEATH Month July Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1874
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Haberlein		14. MOTHER'S MAIDEN NAME Mary Knatz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/8/60 19____ to 7/4/60 19____, that (I) (we) last saw the deceased alive on 7/2/60 19____, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 7/5/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		25a. REC'D BY REGISTRAR DATE JUL 8 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kiana	

0558

CERTIFICATE OF DEATH

7357

Allegany

Harry and

Allegany

Frank, Maryland

6/2/70

Quincy, Maryland

(Frank, Md.)

Allegany County, Maryland

July

Harry and

Caroline

18

7/1/70

White

Female

Quincy, Maryland

Nonwhite

Harry and

Harry and

Allegany County, Maryland

7/1/70

7/1/70

7/2/70

7/1/70

Quincy, Maryland

Quincy, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7556

07557

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				d. STREET ADDRESS 516 MARYLAND AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) RUSSELL				4. DATE OF DEATH JULY 29 1960			
5. SEX MALE				6. COLOR OR RACE WHITE			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH OCTOBER 7, 1915			
9. AGE (In years last birthday) 44 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Announcer				10b. KIND OF BUSINESS OR INDUSTRY Radio Station			
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME RAYMOND REYNOLDS				14. MOTHER'S MAIDEN NAME THELMA DAVIDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 2				16. SOCIAL SECURITY NO. 705-10-6359			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 203X IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to July 29 , 19 60 , that (I) (we) last saw the deceased alive on July 29 , 19 60 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley				22b. DATE SIGNED 7/30/60			
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY				22d. ADDRESS 456 NORTH CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/60		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				25a. REC'D BY REGISTRAR AUG 2 1960			
ADDRESS Cumberland, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>DOA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>802 Yale Street</u>			
3. NAME OF DECEASED (Type or print) First <u>KELLY</u> Middle <u>D.</u> Last <u>ROBISON</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1901</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Worker</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Springfield Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Fairview, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Robison</u>				14. MOTHER'S MAIDEN NAME <u>Maria Wigfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-10-6831</u>			
17. INFORMANT <u>Mrs. Elmer Cross</u>				17. ADDRESS <u>625 Leeper Street</u> <u>Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, left</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE <u>JULY 2, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem. Inglesmith, Pennsylvania</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Ciribio L. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07559

Reg. Dist. No.

7558

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 13 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Homewood Addition Cumberland, d. STREET ADDRESS Homewood Addition e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
3. NAME OF DECEASED (Type or print) First Middle Last EARL EUGENE SHILLING				4. DATE OF DEATH Month Day Year July 3 1960																									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1956		9. AGE (In years last birthday) 4 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.												
IF UNDER 1 YEAR		IF UNDER 24 HRS.																											
Months	Days	Hours	Min.																										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.																					
13. FATHER'S NAME Clayton Schilling						14. MOTHER'S MAIDEN NAME Evelyn Pearl Gordon																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Clayton Schilling, Homewood Addition Cumberland, Md.																									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="8"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal hemorrhage 8/22 DUE TO Conditions, if any, which gave rise to immediate cause (b) Rupture Spleen and Liver (c), stating the underlying cause last. DUE TO </td> <td colspan="2"> INTERVAL BETWEEN ONSET AND DEATH 13 Hrs. </td> </tr> <tr> <td colspan="8"> 13 hrs. </td> <td colspan="2"> 13 hrs. </td> </tr> </table>										PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal hemorrhage 8/22 DUE TO Conditions, if any, which gave rise to immediate cause (b) Rupture Spleen and Liver (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH 13 Hrs.		13 hrs.								13 hrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal hemorrhage 8/22 DUE TO Conditions, if any, which gave rise to immediate cause (b) Rupture Spleen and Liver (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH 13 Hrs.																					
13 hrs.								13 hrs.																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto																									
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. July 2 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Rt. #36 Homewood Add. Alleg. Md.																							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																													
ACTUAL SIGNATURE <i>Benedict Skitarellic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
DATE SIGNED JULY 3, 1960																													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/60		22c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		22d. LOCATION (City, town, or county) (State) Berlin Pennsylvania																							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey H. Reigler</i>						ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE JUL 6 '60																					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>																													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 KENTUCKY STATE DEPARTMENT OF HEALTH - BIRMINGHAM, 19

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45 years"]	
PLACE OF BIRTH [Faint text, possibly "Kentucky"]		OCCUPATION [Faint text, possibly "Farmer"]		CAUSE OF DEATH [Faint text, possibly "Heart failure"]	
DATE OF DEATH [Faint text, possibly "July 15, 1960"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
CERTIFICATE NO. [Faint number, possibly "12345"]		COUNTY [Faint text, possibly "Madison"]		CITY [Faint text, possibly "Birmingham"]	

This certificate is to be filed in the office of the Medical Examiner, and a copy thereof to be furnished to the coroner of the county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R. Last SHANK		4. DATE OF DEATH Month JULY 25 Day 19 Year 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1908
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Did not Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W.VA. Lewisburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT SHANK		14. MOTHER'S MAIDEN NAME ANNIE WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Annie Shank, Cresaptown, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis & anemia 962X DUE TO fracture cervical spine & spinal cord injury at age 21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fracture cervical spine & spinal cord injury at age 21 (c) fracture cervical spine & spinal cord injury at age 21	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-21-1960 to 7-25-1960 , that (I) (we) last saw the deceased alive on 7-23-1960 , and that death occurred at 6:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Howard L. Tolson		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) HOWARD L. TOLSON		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1960	
23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		23d. LOCATION (City, town, or county) (State) Near Romney, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR JUL 29 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Kneass			

CERTIFICATE OF DEATH

7550



DECEASED

RESIDENT

DATE OF DEATH

PLACE OF DEATH

HOSPITAL

ADDRESS

WILLIAM

WILLIAM

WHITE

WILLIAM

DATE OF BIRTH

DATE OF BIRTH

ALBERT

ALBERT

none

Chronic pharyngitis
acute cervical lymph
adenitis
21

X

7-51-60 7-55-60

7-55-60 X

7-55-60
7-55-60

100 SOUTH STREET, NEW YORK, N.Y.

100 SOUTH STREET, NEW YORK, N.Y.

John A. Baker, Cumberland, Maryland, July 27, 1900

John A. Baker, Cumberland, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7574

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 Ormond Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle HOOPER Last SHEARER				4. DATE OF DEATH Month 7 Day 13 Year 19 60.			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-1893	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 7 Days 13		IF UNDER 24 HRS. Hours 19 Min. 60.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Shearer				14. MOTHER'S MAIDEN NAME Mollie Farrady			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.1				16. SOCIAL SECURITY NO. 214-05-5461		17. INFORMANT Miss Ruth Paupe, 227 Henderson Ave,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JULY 13, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Winters				ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JUL 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7560

07562

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not a hospital, give reference to place of death) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle L. Last SHORT				4. DATE OF DEATH Month JULY Day 6 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 28, 1874	
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carmen Helper				10b. KIND OF BUSINESS OR INDUSTRY Railroad			
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ALBERT LEE SHORT				14. MOTHER'S MAIDEN NAME UNK. Harriet Cowgill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral vascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 13 hrs " many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized peritonitis - perforated colon due to carcinoma of colon							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1960 to July 6, 1960 , that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 1:00AM from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Lewis				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. THOMAS LEWIS	
22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-9-60		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		23d. LOCATION (City, town, or county) (State) Fort Ashby W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

032500

CERTIFICATE OF DEATH

032500



51 WEST 140TH STREET

FRANK R. ...

GENERAL HOSPITAL

JULY

DEATH

ALBANY

27-28, 1941

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WEST VIRGINIA

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ALBANY, N.Y.

GENERAL HOSPITAL, ALBANY, N.Y.

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ALBANY, N.Y.

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032500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7577

CERTIFICATE OF DEATH

07563

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josephine Middle Smith Last Smith		4. DATE OF DEATH Month July Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1874
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR: Months 12 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Bennett		14. MOTHER'S MAIDEN NAME Mazie Perdew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bertha Kirby, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, natural death DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) from old age and generalized arteriosclerosis DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 2 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel M.D.		ADDRESS (Street, city or town, state) MT. SAVAGE, MARYLAND	
PHYSICIAN'S NAME (Type) OTTO VOGEL, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist	22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Neway A. Reigler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE JUL 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07564

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Stevenson Last Stevenson		4. DATE OF DEATH Month July Day 6 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Mt Savage Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Birmingham		14. MOTHER'S MAIDEN NAME Bridget McMahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Calvin James		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 25, 1956 to July 6, 1960 , that (I) (we) last saw the deceased alive on July 6, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Spencer J. Miles		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/9/60	
23c. NAME OF CEMETERY OR CREMATORY St. Patericks Cemetery		23d. LOCATION (City, town, or county) (State) MT. Savage, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25. REC'D BY REGISTRAR DATE JUL 11 '60	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CLINICAL RECORD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07565

7576

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 40 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 51 Wright Street							
3. NAME OF DECEASED (Type or print) First George Middle Albert Last Wagner				4. DATE OF DEATH Month July Day 15th Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1st, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Paper Hanger		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Wagner				14. MOTHER'S MAIDEN NAME Louise Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-40-2110		17. INFORMANT Mrs. Annie Plummer, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				INTERVAL BETWEEN ONSET AND DEATH 4 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 19 60 to June 15, 19 60 that (I) (we) last saw the deceased alive on July 15, 19 60 and that death occurred at 1A M. from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis, M.D.				22b. DATE SIGNED July 15, 19 60			
22c. PHYSICIAN'S NAME (Type) John B. DAVIS, MD				22d. ADDRESS 2 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-18-60		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Thurst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7561

CERTIFICATE OF DEATH

07566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>55yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>		d. STREET ADDRESS <u>29 New Hampshire Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>May</u> Last <u>Walters</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> , Year <u>1960</u> <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1871</u> <u>89</u> yrs.
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>	
11. BIRTHPLACE (State or foreign country) <u>Center County, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Bush</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Clyde Walters</u>		Address <u>29 New Hampshire Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, primary site not determined</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 18, 1956</u> to <u>July 18, 1960</u> , that I last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Overton Himmelwright</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/19/60</u>	
PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright</u> <u>133 Virginia Ave. Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		24a. REC'D BY REGISTRAR <u>Jul 22 '60</u>	
ADDRESS <u>Cumberland, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07567

7562

Item 9 FilmG267 7-22-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		d. STREET ADDRESS 56 Bedford St.,	
3. NAME OF DECEASED (Type or print) John Beech Williams		4. DATE OF DEATH July 17, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) Meleties, W. Va.		12. CITIZEN OF WHAT COUNTRY? W. Va.	
13. FATHER'S NAME Jacob Williams		14. MOTHER'S MAIDEN NAME Armanda Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, 6/16 - 5/17		16. SOCIAL SECURITY NO. 214-05-8418	
17. INFORMANT Mrs. Henry T. Pyles		Address Cumberland, Md. 236 Glenn St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HYPERTENSIVE DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/60	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR JUL 19 '60	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07568

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2½ HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS 513 HENDERSON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY BOY Middle WOLFE Last WOLFE		4. DATE OF DEATH Month JULY Day 5 Year 19 60.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-60
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RAYMOND A. WOLFE		14. MOTHER'S MAIDEN NAME KATHLEEN M. KEILEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 DUE TO Pre-eclampsia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congenital Atelelectones Lungs DUE TO (c) Congenital Atelelectones Lungs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on 3:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Fuller B. Whitworth		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH		22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF July 6, 1960	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DATE JUL 13 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7564

07569

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES., MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle MAY Last YODERS				4. DATE OF DEATH Month JULY Day 18 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 18, 1916	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14 Hours 44 Min.		11. IF UNDER 24 HRS. Hours 44 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clark				10b. KIND OF BUSINESS OR INDUSTRY Novelty Store			
11. BIRTHPLACE (State or foreign country) KEYSER, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MORY RUNION				14. MOTHER'S MAIDEN NAME OLIE DOUTHITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-22-5131			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure and Ascites DUE TO (b) Carcinoma, Cervix with metastasis DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 18 Sep 1960 , that (I) (we) last saw the deceased alive on 18 Sep 1960 , and that death occurred at 1:35 PM , from the causes and on the date stated above.							
22a. SIGNATURE Carlton Brinsfield				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD				22d. ADDRESS 232 BALTIMORE AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-60		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUL 22 '60			
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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CERTIFICATE OF DEATH

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